Eleven steps to revitalize the practice of medicine

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For 30 years I have worked as an academic physician treating patients, teaching trainees of all levels, and conducting research. I find my job tremendously gratifying spiritually, emotionally, and intellectually, which is why it is so painful to watch it decline in front of my eyes.

(Article by Allon Friedman republished from AllonFriedman.org)

In recent years forces arising from inside and outside my profession have worked to degrade core tenets of medical practice like physician autonomy, professional excellence, and the physician-patient relationship. These forces are succeeding in large measure because of increasingly centralized power among a variety of actors and a suffocating blanket of regulations and bureaucracy. The result? Physician dissatisfaction and burnout and deterioration of the medical profession. As physicians go so goes the health care system, so this is a crisis that affects every American.

I believe, however, that it is not too late to reverse this trend. That is why I would like to bring to the attention of the incoming Trump administration, which ran on a platform of reform, my personal list of restorative strategies. I believe instituting reform in the specific areas I outline

below would correct some of the worst problems that physicians are currently facing, reinvigorate the medical profession, and improve medical care.

In large part, the key to succeeding involves decentralizing and demonopolizing power and rolling back regulatory hurdles within the system. My list is by no means exhaustive (for example, I don't touch on reimbursement issues) nor is it presented in any particular order, but it is one that speaks directly to my personal experience:

Medical Training

1. As the experience at the U of Michigan and many other institutions has shown, Critical Race Theory in the form of Diversity Equity and Inclusion (DEI) is divisive and encourages a grievance-based mentality, rewards group affiliation over individual excellence, and is contrary to US civil rights law. Nevertheless, DEI has in a relatively short period completely captured all aspects of institutionalized medicine. In my opinion, the damage that DEI has inflicted on my profession has been immense, which is why it must be completely expunged from the medical field. The incoming administration can do this using existing civil rights laws to apply financial and other penalties to institutions that continue to promote DEI.

2. In recent years medical institutions have replaced numerical grading of standardized and non-standardized tests with pass/fail grades. This occurred in parallel with DEI-based attempts to obscure academic differences between trainees by removing objective scoring methods. The most pernicious effect of this change is to make it difficult to assess and identify academic excellence, thus forcing the system to replace objective, easily interpretable, and longstanding measurements with far less rigorous ones. This problem can be corrected using existing civil rights laws by addressing the underlying rationale for switching to pass/fall grading (i.e. DEI).

3. Though technology has undoubtedly improved the diagnostic and treatment capabilities of physicians, its growing use has paralleled a diminishing emphasis on bedside physical exams and clinical skills, which have been at the heart of medical practice and the patient-physician relationship for millennia. Before they are altogether lost, medical institutions must redouble efforts to highlight the essential nature of such skills during the educational process, including instituting a national clinical skills exam for all medical students. Reemphasizing such skills will have several important benefits, including rekindling in trainees an appreciation for how much vital clinical information can be obtained just through their powers of observation and the laying-on of hands; strengthening the human bond between physician and patient; reducing unnecessary testing; and lowering costs. The best medical care is administered by physicians who use technology to complement, and not replace, their bedside skills.

4. Open debate on a variety of subjects within academic medicine has been increasingly stifled in recent years, while dissenters have been sidelined if not outright punished. This is a critical issue for a field that requires disagreement and debate to advance. The new administration can encourage medical institutions, particularly training institutions, to enrich their environment with civil debate by ensuring that funding goes hand-in-hand with academic freedom. An example would be routinely sponsoring conferences that include pro-con debates on major medical controversies. Such a move will educate physicians, and most importantly trainees, that medicine is not "settled science" but a constantly evolving field that requires ongoing critical reevaluation.

5. The new administration must critically evaluate the role of agencies that provide accreditation to medical training programs and hospital systems. While these agencies argue that their work is necessary to ensure quality of care and patient safety, they are run by unaccountable and unelected bureaucrats who quite literally have the power of "life and death" over such institutions. If training programs or hospital systems refuse to accept the demands of such agencies, no matter how extreme or burdensome, they can withhold their accreditation and put them out of business. DEI has become institutionalized in medical schools in no small part because of these accrediting agencies. The Trump administration can legally challenge the monopolization of power that these agencies currently possess to make their recommendations voluntary rather than compulsory as they currently are.

Medical Practice

1. The increasing consolidation of medical hospitals and institutions and their physician employees spurred on by federal regulation over decades has led to reduced choice, less innovation, higher costs, shrinking physician independence, and the increasing replacement of physicians by less expensive nurse practitioners and physician assistants. The Trump administration must roll back these regulations that have over time forced physicians in independent practice to become employees of large hospital and health care systems. Removing existing regulatory obstacles that prevent physicians from owning hospitals and other medical facilities would also help. Instituting these changes will strengthen innovation and competition within the medical field leading to greater choice, better care, and lower costs.

2. The new administration should remove legislation that forces physicians to participate in federal value-based care systems and models. While these models were designed to improve quality of medical care, not only have they not demonstrated any benefit, they force physicians to invest huge amounts of their own time and resources to fulfill project requirements (while simultaneously sometimes even seeing their reimbursement lowered!). The huge resource burden required by value-based programs is one important

reason for increasing consolidation in the medical field. Medical innovation would be much more effectively introduced in a “bottom-up” fashion by increasing competition, choice, and freedom within medical practice.

3. The new administration should abandon regulations that require physicians to adhere to numerous “quality” care guidelines or measures that have not been proven to be superior to standard clinical practice but are burdensome and detract from clinical care. As a kidney doctor, I am constantly frustrated by the time and effort that the Centers for Medicare and Medicaid Services force me to spend achieving “quality” measures for my dialysis patients that are unproven and possibly even detrimental.

4. One of the principal forces leading to physician unhappiness and burnout is the requirement that physicians use electronic medical records (EMRs), which are essentially billing software repurposed for patient care. These systems add hours of untold frustration to physicians’ already exhausting daily schedule, reduce the quality of medical notes, and increase documentation errors. The Trump administration could improve the situation by rolling back regulations that require the use of EMRs in hospitals and health care systems. Physicians could return to free-form writing or dictating until EMR systems are introduced that are more intuitive and easier to use.

5. Medical institutions are increasingly tolerating, and sometimes even promoting, narcissistic behavior among their staff. By that I mean medical trainees or physicians who through dress, appearance, behavior or other manners of personal presentation, force their own worldview onto patients regardless of how uncomfortable it may make the patient feel. This self-absorbed behavior undermines a fundamental tenet of medicine, namely that physicians place their patients’ well-being above their own interests and withhold judgment of patients. Patients should not have to tolerate this behavior and medical institutions should censure individuals who behave in this manner.

6. Currently, most medical institutions require that physicians obtain continuing medical education (CME) credits and maintenance of professional certification from only a few select private organizations that make outrageous sums of money off the backs of physicians. Using antitrust legislation the new administration can break this monopoly and allow alternative CME and certification options that are more flexible and much less expensive.

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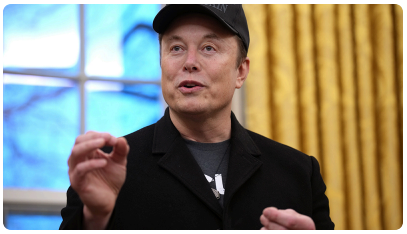

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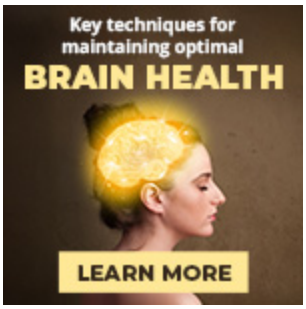

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